No. 85-225

Supreme Court, U.S.
FILED
AUG 9 1985
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

CHARLES FRIED
Acting Solicitor General
RICHARD K. WILLARD
Acting Assistant Attorney General
KENNETH S. GELLER
Deputy Solicitor General
EDWIN S. KNEEDLER
Assistant to the Solicitor General
ANTHONY J. STEINMEYER
HAROLD J. KRENT
Attorneys
Department of Justice
Washington, D.C. 20530
(202) 633-2217

BEST AVAILABLE COPY

QUESTION PRESENTED

Whether, notwithstanding the preclusions of review in 42 U.S.C. 1395ff and 405(h), the district court properly exercised jurisdiction under 28 U.S.C. 1331 to entertain respondents' challenge to a regulation affecting the amount of benefits payable for medical services under Part B of the Medicare Program.

PARTIES TO THE PROCEEDING

The petitioners are Margaret M. Heckler, Secretary of Health and Human Services, and Blue Cross and Blue Shield of Michigan, an insurance carrier that has contracted with the Secretary pursuant to 42 U.S.C. 1395u to administer the Part B Medicare Program in Michigan on her behalf.

The respondents are: (1) the Michigan Academy of Family Physicians, a nonprofit association of family physicians in Michigan; (2) Lester Webb and Charles Farber, family physicians who are eligible for specialist certification under the standards of the American Board of Family Practice but who have not been certified as specialists under those standards; (3) Glenn House, a family physician certified as a specialist under the standards of the American Board of Family Practice; and (4) Carol A. Diedrich, a resident of Michigan and a Medicare Part B recipient whose treating physician, Philip Lange, is a family physician who is neither Board-certified nor Board-eligible.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statutory provisions and regulation involved	2
Statement	2
A. The statutory framework	2
B. The proceedings in this case	5
Reasons for granting the petition	10
Conclusion	22
Appendix A	1a
Appendix B	16a
Appendix C	17a
Appendix D	23a
Appendix E	34a
Appendix F	35a
Appendix G	36a

TABLE OF AUTHORITIES

Cases:

American Federation of Home Health Agencies, Inc. v. *Heckler*, 754 F.2d 896	21
Bio-Medical Applications of Providence, Inc. v. *Heckler*, 593 F. Supp. 1233, appeal pending, No. 84-5802 (D.C. Cir.)	22
Block v. *Community Nutrition Institute*, No. 83-458 (June 4, 1984)	19
Erika, Inc. v. *United States*, 634 F.2d 580	15
Ganem v. *Heckler*, 746 F.2d 844	21
Heckler v. *Community Health Services*, No. 83-56 (May 21, 1984)	3, 4

Cases—Continued: Page

Heckler v. *Redbud Hospital Dist.*, No. A-32 (July 24, 1985) 3
Heckler v. *Ringer*, No. 82-1772 (May 14, 1984) ..... *passim*
Heckler v. *Starnes*, No. 83-1149 (June 4, 1984) 20
Hutto v. *Davis*, 454 U.S. 370 11
Linoz v. *Heckler*, 598 F. Supp. 486, appeal pending, No. 84-2446 (9th Cir.) 22
National Association of Patients on Hemodialysis & Transplantation, Inc. v. *Heckler*, 588 F. Supp. 1108 22
Schweiker v. *McClure*, 456 U.S. 188 ..... 4, 16, 21
Smith v. *North Louisiana Medical Review Ass'n*, 735 F.2d 168 21
Starnes v. *Schweiker:*
715 F.2d 134 20
748 F.2d 217, cert. denied, No. 84-1309 (Apr. 15, 1985) 11, 20, 21
United States v. *Erika, Inc.*, 456 U.S. 201 . *passim*
Weinberger v. *Salfi*, 422 U.S. 749 ..... 8, 17

Statutes and regulations:

Social Security Act, 42 U.S.C. 301 *et seq.*:
Tit. II, 42 U.S.C. 401 *et seq.* 21
42 U.S.C. 405(g) 3, 8, 12, 17, 18
42 U.S.C. 405(h) ..... *passim*
Tit. XVI, 42 U.S.C. 1381 *et seq.* 21
Tit. XVIII, 42 U.S.C. 1395 *et seq.*:
42 U.S.C. 1395c 2
42 U.S.C. 1395d 2
42 U.S.C. 1395h 2-3, 12

Statutes and regulations--Continued: Page

42 U.S.C. 1395k 2
42 U.S.C. 1395*l* 2
42 U.S.C. 1395u 2, 4, 36a
42 U.S.C. 1395u(b)(3) 5, 7, 8, 37a
42 U.S.C. 1395u(b)(3)(B) 5, 37a
42 U.S.C. 1395u(b)(3)(B)(ii) 18, 37a
42 U.S.C. 1395u(b)(3)(C) 4, 19, 38a
42 U.S.C. 1395x(s) 2
42 U.S.C. 1395ff ..... *passim*
42 U.S.C. 1395ff(a) 12, 14, 39a
42 U.S.C. 1395ff(b) 12, 14, 39a
42 U.S.C. 1395ff(b)(1)(C) 3, 4, 39a
42 U.S.C. 1395ff(b)(2) 3, 40a
42 U.S.C. 1395ii 8, 12, 16
42 U.S.C. 1395*oo* 3, 5
42 U.S.C. 1395*oo*(a) 4
42 U.S.C. 1395*oo*(c) 4
42 U.S.C. 1395*oo*(f)(1) 4, 19
42 U.S.C. 1395ww 3
28 U.S.C. 1331 ..... *passim*
42 C.F.R.:
Section 405.502 5
Section 405.502(d) 4
Section 405.504(b) 2, 5, 7, 40a
Sections 405.710-405.716 3
Section 405.801(a) 5, 19
Section 405.860 15

Miscellaneous:

H.R. Conf. Rep. 92-1605, 92d Cong., 2d Sess. (1972) 13
S. Rep. 404, 89th Cong., 1st Sess. (1965) 13

In the Supreme Court of the United States

OCTOBER TERM, 1985

No.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services and Blue Cross and Blue Shield of Michigan, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The original opinion of the court of appeals, dated February 23, 1984 (App., *infra*, 1a-15a), is reported at 728 F.2d 326. The November 5, 1984 order of the court of appeals (App., *infra*, 16a), following the remand by this Court, is reported at 751 F.2d 809, and the March 19, 1985 order of the court of appeals on respondents' petition for rehearing (App., *infra*, 17a-22a) is reported at 757 F.2d 91. The opinion of the district court (App., *infra*, 23a-33a) is reported at 502 F. Supp. 751.

JURISDICTION

The judgment of the court of appeals was entered on March 19, 1985. The Secretary's timely petition for re-

hearing was denied on May 30, 1985 (App., *infra*, 35a). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS AND REGULATION INVOLVED

28 U.S.C. 1331; relevant provisions of Sections 205(h), 1842 and 1869 of the Social Security Act, 42 U.S.C. 405(h), 1395u and 1395ff; and 42 C.F.R. 405.504(b) are reproduced at App., *infra*, 36a-40a.

STATEMENT

The court of appeals held in this case that the district court had jurisdiction to entertain a challenge to a regulation affecting the amount of benefits to be paid for physicians' services under Part B of the Medicare Program. This Court previously vacated the judgment of the court of appeals and remanded for further consideration in light of *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984). See No. 84-120 (Oct. 1, 1984). After initially concluding on remand that *Ringer* required dismissal of this suit, the court of appeals subsequently reinstated its prior holding that the district court had jurisdiction.

A. The Statutory Framework

The Medicare Program is divided into two parts. Part A provides insurance for the reasonable cost of hospital and related post-hospital services. 42 U.S.C. 1395c, 1395d. Part B establishes a voluntary program of supplementary medical insurance covering, in general, 80% of the "reasonable charge" for physicians' and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

1. Part A of the Medicare Program authorizes the Secretary to enter into contracts with fiscal intermediaries under which the intermediaries determine whether particular services are covered by Part A and, if so, the amount of benefits that are payable. 42

U.S.C. 1395h. See *Ringer*, slip op. 2-3. If the intermediary determines that a particular service is not covered by Part A, the claimant is entitled to seek reconsideration by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS). 42 C.F.R. 405.710-405.716. If the intermediary's denial of the claim is affirmed on reconsideration and the amount in controversy is at least $100, the claimant has a statutory right to an evidentiary hearing on the claim before an administrative law judge (ALJ) in HHS. 42 U.S.C. 1395ff(b)(1)(C) and (2). If the ALJ denies the claim and the Appeals Council sustains that decision, the claimant may seek judicial review pursuant to 42 U.S.C. 405(g) if the amount in controversy is $1,000 or more. 42 U.S.C. 1395ff(b)(1)(C) and (2). See *Ringer*, slip op. 3. On judicial review, the court may consider the validity of any regulation that has the effect of limiting or denying Part A benefits to the claimant. See *Ringer*, slip op. 10-11, 13.

The Medicare Act also provides a mechanism for a hospital or other provider of Part A services to obtain review of the amount it will be reimbursed. A provider is paid an aggregate amount for all Part A services it rendered during the relevant time period. See *Heckler* v. *Community Health Services*, No. 83-56 (May 21, 1984), slip op. 2.[1] If the provider is dissatisfied with the intermediary's determination of the total amount of re-

---

[1] The method of calculation of payments under Part A has been revised by the enactment of Section 1886 of the Act, 42 U.S.C. 1395ww, which adopts a prospective payment system and directs that providers be reimbursed at a flat rate for particular services. See *Heckler* v. *Redbud Hospital Dist.*, No. A-32 (July 24, 1985), slip op. 1-2 (Rehnquist, Circuit Justice). However, the rights of beneficiaries and providers to administrative and judicial review under Part A continue to be governed by the express provisions in 42 U.S.C. 1395ff and 1395*oo*, which are discussed in the text.

imbursement due and if the amount in controversy is $10,000 or more, the provider may request a hearing before the Provider Reimbursement Review Board (PRRB) in HHS. 42 U.S.C. 1395*oo*(a) and (c). If the decision of the PRRB is adverse to the provider, it then may seek judicial review in federal district court. 42 U.S.C. 1395*oo*(f)(1); *Heckler* v. *Community Health Services*, slip op. 6. The Act expressly allows the provider to obtain judicial review on a question involving the validity of a regulation that has the effect of limiting the amount of reimbursement. 42 U.S.C. 1395*oo*(f)(1).

2. The Part B Medicare Program, at issue here, provides for far more limited review of benefit determinations. The Secretary is authorized to enter into contracts with private insurance carriers under which the carriers determine whether the particular services for which a beneficiary has submitted a claim are covered by Part B and the amount of the "reasonable charge" for such services. 42 U.S.C. 1395u; see *Schweiker* v. *McClure*, 456 U.S. 188, 190 (1982). If the carrier determines that the services for which reimbursement is sought are not covered by Part B or that the payment due is less than the amount claimed, the claimant is entitled by statute to a hearing conducted by the carrier. 42 U.S.C. 1395u(b)(3)(C); see *Schweiker* v. *McClure*, 456 U.S. at 191. However, in contrast to the Part A Program, there is no provision for administrative review by HHS of the carrier's denial of a Part B claim. 42 C.F.R. 405.502(d). Moreover, although 42 U.S.C. 1395ff(b)(1)(C) expressly authorizes a claimant to obtain judicial review of the "amount of benefits" under Part A, there is no parallel provision in 42 U.S.C. 1395ff for a claimant to obtain judicial review of the amount payable on a Part B claim. In *United States* v. *Erika, Inc.*, 456 U.S. 201, 206-211 (1982), this Court held that by this omission, Congress "deliberately intended to fore-

close further review of such claims" (456 U.S. at 208). Accord *Ringer*, slip op. 5 n.4.

The Act likewise does not contain any special procedures, similar to those available to Part A providers under 42 U.S.C. 1395*oo*, for a physician or other supplier of Part B services to obtain administrative review by HHS or judicial review of the amount of benefits payable. If the enrollee assigns his Part B Medicare reimbursement claim to the physician or other person who furnished the services, the assignee has the same right as a beneficiary to an evidentiary hearing by the carrier. 42 C.F.R. 405.801(a); *Erika*, 456 U.S. at 203, 207 n.7. But as the Court held in *Erika*, the assignee has no right to judicial review of the carrier's decision.

B. The Proceedings In This Case

1. The Social Security Act requires the carriers that administer the Part B Program on the Secretary's behalf to make payment for covered services on the basis of the "reasonable charge" for the services. 42 U.S.C. 1395u(b)(3)(B). In determining the reasonable charge, the carrier is to "take[ ] into consideration the customary charges for similar services generally made by the physician * * * as well as the prevailing charges in the locality for similar services." 42 U.S.C. 1395u(b)(3). Applying these principles, the reasonable charge for a physician's services ordinarily is the lowest of (1) the actual charge in the particular instance, (2) the individual physician's customary charge, and (3) the prevailing charge in the locality for similar services (App., *infra*, 2a-3a). See 42 C.F.R. 405.502.

In 1967, the Secretary promulgated the regulation at issue in this case, which recognizes that "[t]he range of prevailing charges in a locality may be different for physicians * * * who engage in a specialty practice or service than for others." 42 C.F.R. 405.504(b). The regulation accordingly permits (but does not require) a carrier, based on "[e]xisting differentials in the level of

charges between different kinds of practice or service," to develop more than one range of prevailing charges.

Consistent with this regulation, Blue Cross/Blue Shield of Michigan (BC/BSM), the carrier responsible for administering the Part B Program in Michigan, conducted a statistical analysis of physicians' charges in that State in 1968. Based on its analysis, BC/BSM identified three categories of physicians for reimbursement purposes: (1) hospital internists and other hospital specialists, (2) other specialists, and (3) general practitioners and other nonspecialists. The prevailing charges for specialists in Michigan were higher than those for nonspecialists, and a Part B beneficiary therefore could receive a greater reimbursement if he was treated by a specialist. App., *infra*, 4a. Following creation of the family practice specialty, BC/BSM in 1973 classified Board-certified family practitioners in the specialist category, but family physicians who were merely eligible for Board certification and family physicians who were neither Board-eligible nor Board-certified were grouped with the nonspecialists. *Ibid.*[2]

2. Respondents filed this action on October 8, 1976 in the United States District Court for the Eastern District of Michigan to challenge BC/BSM's classification of family practitioners (C.A. App. 1, 11-29). The initial plaintiffs were the Michigan Academy of Family Physicians, one Board-certified family practitioner, and two Board-eligible family practitioners (C.A. App. 19). Later, a Part B enrollee who was the patient of a family practitioner who was neither Board-certified nor Board-eligible was joined as a plaintiff (App., *infra*, 31a-32a).

The district court held that the establishment of separate charge screens that distinguish non-Board certi-

[2] The government acknowledged in proceedings in district court in this case that Board-eligible family physicians should have been included in the specialist category (App., *infra*, 27a).

fied family physicians from other physicians violated the Medicare Act and that to the extent 42 C.F.R. 405.504(b) authorized the screens established by BC/BSM, it was invalid. The court relied on 42 U.S.C. 1395u(b)(3), which requires the carrier to "take[ ] into consideration" the prevailing charges for "similar services" and to establish a ceiling based on the prevailing charge level that would cover 75% of the customary charges for "similar services" in the locality. In the court's view, these provisions required that similar services be reimbursed at an identical rate, even when performed by physicians with different degrees of specialization. App., *infra*, 29a-30a. The court also was of the view that the maintenance of three charge screens impermissibly "tends to influence the patient's choice of a physician" (*id.* at 30a-31a). Finally, the court concluded that BC/BSM did not have an adequate factual or statistical basis for distinguishing among groups of physicians (*id.* at 28a). As a remedy, the district court ordered the Secretary and BC/BSM to establish two categories for determining prevailing charges: the first for all physicians, and the second for chiropractors, podiatrists, and dentists (*id.* at 32a-33a).

3. a. In an opinion dated February 23, 1984, the court of appeals affirmed the district court's ruling but modified the remedy (App., *infra*, 1a-15a). As a threshold matter, the court of appeals rejected the Secretary's contention that the district court's exercise of jurisdiction under 28 U.S.C. 1331 was barred by 42 U.S.C. 1395ff and 405(h) (App., *infra*, 6a-11a). The court recognized that this Court's decision in *Erika* foreclosed judicial review of the amount of reimbursement for services under Part B of the Medicare Program (App., *infra*, 6a-8a). But the court observed that in the wake of *Erika*, several lower courts had "strenuously endeavored to find jurisdiction" over challenges to certain aspects of the Medicare Program (App.,

infra, 8a), and it elected to do the same. Thus, although the court of appeals acknowledged that "the eventual result of this suit may cause an increase in amounts of reimbursement" for services rendered by family physicians (*ibid.*), it nevertheless held that this suit was not barred by the preclusion of review in 42 U.S.C. 1395ff because respondents were challenging the "mechanism" for computing the reasonable charge for particular services, not the reasonable charge itself (App., *infra*, 8a-9a).

The court of appeals further concluded that the district court's exercise of federal question jurisdiction under 28 U.S.C. 1331 was not barred by 42 U.S.C. 405(h), as incorporated into the Medicare Program by 42 U.S.C. 1395ii (App., *infra*, 9a-11a). The court acknowledged that in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and subsequent decisions, this Court had held that the third sentence of Section 405(h) prohibited a court from exercising federal question jurisdiction to entertain any claim arising under the Social Security Act. But it noted that in *Salfi* and the other decisions, this Court had referred to the availability of an alternative method for obtaining judicial review pursuant to 42 U.S.C. 405(g). Because there is no provision for review of Part B Medicare claims under 42 U.S.C. 405(g), the court of appeals reasoned that 42 U.S.C. 405(h) should not be construed to preclude federal question jurisdiction over a suit arising under Part B. App., *infra*, 10a-11a.

b. On the merits, the court of appeals held that BC/BSM's calculation of the amount of reimbursement for family physicians' services by reference to the separate prevailing charge screens was invalid (App., *infra*, 11a-14a). In the court's view, the "touchstone of [42 U.S.C. 1395u(b)(3)] is that similar services, once determined, are to be compensated equally, regardless of who performs them" (App., *infra*, 12a). The court further explained that its decision to invalidate the regula-

tion was "bolstered" by its view that the reimbursement approach BC/BSM followed might create an added incentive for physicians to become specialized and for patients to seek specialized care (*id.* at 13a-14a). The latter incentive, the court believed, was sufficient to support a finding that "the regulation as applied violates 42 U.S.C. § 1395a, prohibiting infringement of a patient's free choice of a physician" (App., *infra*, 14a). However, the court of appeals concluded that the district court's remedy went "too far," and it instead remanded the case to the Secretary "with instructions to consider similar services in an equal manner regardless of who performs that service" (*id.* at 14a-15a).

4. The Secretary and BC/BSM then filed a petition for a writ of certiorari, arguing that the court of appeals' jurisdictional ruling was inconsistent with this Court's decisions in *Ringer* and *Erika*. The Court granted the petition, vacated the judgment of the court of appeals, and remanded the case to the court of appeals for further consideration in light of *Ringer*. See No. 84-120 (Oct. 1, 1984).

5. On remand, the court of appeals at first remanded the case to the district court with instructions to dismiss for lack for jurisdiction, explaining that "the principles stated by the Supreme Court in *Heckler* v. *Ringer* require us to find that the federal courts lack jurisdiction over the present case" (App., *infra*, 16a). However, on respondents' petition for rehearing, the panel reversed itself once more and held that *Ringer* and *Erika* did not preclude the exercise of jurisdiction in this case (App., *infra*, 17a-22a).

The court of appeals acknowledged in its opinion on rehearing that this Court, in footnote 4 of its opinion in *Ringer*, held that judicial review was barred insofar as that case arose under Part B of the Medicare Program (App., *infra*, 21a). But although this Court expressly

relied for this proposition on its prior decision in *Erika* (see *Ringer*, slip op. 5 n.4), which in turn relied on 42 U.S.C. 1395ff (see 456 U.S. at 206-211), the court of appeals stated that "[i]n reaching its decision in *Heckler* v. *Ringer*[,] the Supreme Court did not rely on § 1395ff" (App., *infra*, 18a n.2). The court of appeals therefore did not discuss 42 U.S.C. 1395ff.

With regard to the additional preclusion of review in 42 U.S.C. 405(h), the court of appeals acknowledged that this Court held in *Ringer* that the challenge to the regulation there at issue fell within the coverage of Section 405(h) (App., *infra*, 19a-20a) and that the application of the jurisdictional bar in Section 405(h) does not depend on whether judicial review of the particular claim is otherwise available under the Social Security Act itself (App., *infra*, 21a-22a). But without explaining why *Ringer* was not therefore dispositive, the court of appeals held that the district court did have jurisdiction in this case under 28 U.S.C. 1331, relying on nothing more than a "presumption" favoring judicial review and its notion that "for every right there must be a remedy" (App., *infra*, 22a). The court of appeals further held that *Ringer* does not in any event foreclose judicial review by "a party other than a claimant for benefits" (App., *infra*, 21a, 22a)—presumably meaning the physicians who challenged the regulation and charge screens but did not submit an actual claim for reimbursement. For the foregoing reasons, the court reinstated its February 23, 1984 opinion sustaining the district court's exercise of jurisdiction under 28 U.S.C. 1331 (App., *infra*, 22a).[3]

REASONS FOR GRANTING THE PETITION

The decision of the court of appeals permitting judicial review of matters pertaining to the amount of bene-

[3] The Secretary's petition for rehearing en banc was denied in an order dated May 30, 1985 (App., *infra*, 35a).

fits payable under the Part B Medicare Program is flatly inconsistent with this Court's decisions in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), and *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984). Those cases, like this one, involved challenges to a regulation or instruction issued by the Secretary that had the effect of limiting the amount of benefits the carrier could award on a particular claim, and the Court's holdings in *Erika* and *Ringer* therefore squarely control this case. The court of appeals' failure to follow *Ringer*, after it was given an opportunity by this Court to do so, is inexplicable. "[U]nless we wish anarchy to prevail within the federal judicial system, a precedent of this Court must be followed by the lower federal courts no matter how misguided the judges of those courts may think it to be." *Hutto* v. *Davis*, 454 U.S. 370, 375 (1982).

In direct conflict with the decision below, the Fourth Circuit recently held, also following a remand by this Court, that *Ringer* required the dismissal for lack of jurisdiction of a challenge to a regulation that had the effect of limiting the amount of benefits payable for particular services under Part B. *Starnes* v. *Schweiker*, 748 F.2d 217 (4th Cir. 1984), cert. denied, No. 84-1309 (Apr. 15, 1985). That conflict warrants resolution by this Court, especially since the decision below threatens to foster once again the widespread litigation on questions pertaining to the amount of reimbursement under Part B that prevailed prior to *Erika*. Because this Court already has resolved the precise issue presented in this case and because the court of appeals offered no substantial basis for distinguishing this case from *Ringer*, there is no need for the Court to grant plenary review here. We therefore suggest that summary reversal of the judgment below is appropriate.

1. Respondents invoked the jurisdiction of the district court under 28 U.S.C. 1331 to challenge the prevailing charge screens used to calculate the amount of

Part B Medicare benefits paid for services furnished by family physicians. Judicial review of such matters is barred by two separate provisions of the Social Security Act. The first is 42 U.S.C. 1395ff, which exclusively governs the availability of judicial review for participants in the Medicare Program, but does not provide for such review of the amount of benefits under Part B. The second is 42 U.S.C. 405(h), as incorporated into the Medicare Program by 42 U.S.C. 1395ii, which precludes the bringing of an action under 28 U.S.C. 1331 to recover on any claim "arising under" the Social Security Act.

a. In 42 U.S.C. 1395ff(a), Congress provided that "the determination of the amount of benefits under part A [of the Medicare Program] shall be made by the Secretary in accordance with regulations prescribed by [her]." The Secretary is authorized to enter into contracts with fiscal intermediaries to make these initial determinations on her behalf. See 42 U.S.C. 1395h. Under 42 U.S.C. 1395ff(b), an individual who is dissatisfied with the intermediary's determination as to "the amount of benefits under part A" is entitled to a hearing before an ALJ in HHS if the amount in controversy is $100 or more and to judicial review, as provided in 42 U.S.C. 405(g), if the amount in controversy is $1,000 or more.

Under Part B, determinations and evidentiary hearings with respect to the amount of benefits on a particular claim are conducted entirely by private insurance carriers; there is no provision in 42 U.S.C. 1395ff(b) for review by HHS. Moreover, as this Court recognized in *Erika* (456 U.S. at 208), 42 U.S.C. 1395ff(b) likewise conspicuously fails to authorize *judicial* review of the "amount of benefits" under Part B, even though it expressly authorizes such review under Part A. In light of the Act's "precisely drawn provisions," the Court in *Erika* found this omission persuasive evidence that

Congress had "deliberately * * * foreclose[d]" judicial review of benefit amount determinations under Part B. 456 U.S. at 208. The Court in *Erika* further found that this preclusion of review was "unambiguously support[ed]" by the legislative history of Section 1395ff. 456 U.S. at 208-211.[4] Respondents' challenge in this case pertains directly to the carrier's calculation of the "amount of benefits" to be paid under Part B for services furnished by family physicians. It therefore is foreclosed by the very text and legislative history of 42 U.S.C. 1395ff that compelled the Court's unanimous holding in *Erika*.

Respondents cannot avoid that conclusion by styling their suit as a challenge only to the regulation issued by the Secretary, not the actual amount of benefits awarded by the carrier. The regulation at issue authorizes (but does not require) a carrier to establish different prevailing charge levels for services performed by physicians and others who have different degrees of specialization. Respondents challenge that regulation precisely because the carrier in Michigan has chosen to establish a different screen for certain family physicians that in turn operates as a ceiling on the amount of benefits payable under Part B for services rendered by those physicians. Indeed, in order even to have standing to bring this suit, respondents must rely on the effect the regulation has on the amount of benefits pay-

---

[4] The Court quoted the Senate Report on the original Medicare Act, which stated that the Act did not provide for judicial review of "a determination concerning the amount of benefits under part B" and that the provision for review by carriers under Part B was intended to be the "exclusive" remedy. See 456 U.S. at 208, 209 n.11, quoting S. Rep. 404, 89th Cong., 1st Sess. 54-55 (1965). The Court also quoted the Conference Report on the 1972 amendments to 42 U.S.C. 1395ff, which explained that "there is no authorization * * * for judicial review on matters solely involving amounts of benefits under Part B" (456 U.S. at 210, quoting H.R. Conf. Rep. 92-1605, 92d Cong., 2d Sess. 51 (1972)).

able (compare *Ringer*, slip op. 11-12), and the court of appeals acknowledged that "the eventual result of this suit may cause an increase in amounts of reimbursement" (App., *infra*, 8a). Thus, the preclusion of review in 42 U.S.C. 1395ff applies fully to challenges to regulations that underlie the carrier's decision concerning the amount of benefits.[5]

Respondents' contention at bottom is that separate charge screens are not authorized by the Medicare Act, which the regulation at issue merely implements. Their legal argument therefore would be exactly the same if the Secretary had never promulgated the regulation and the carrier in Michigan had adopted the separate screens based solely on its own interpretation of the Medicare Act.[6] As *Erika* itself makes clear, such a statutory challenge to the carrier's actions is foreclosed by 42 U.S.C. 1395ff. See 456 U.S. at 204-205. In any event, in *Erika* itself, the plaintiff's claim to increased benefits was based in part on a challenge to instructions issued by the Secretary, which bound the carriers in the same manner as formal regulations (see *Ringer*, slip

---

[5] This conclusion also is evident from the structure of 42 U.S.C. 1395ff. In 42 U.S.C. 1395ff(b), Congress has authorized judicial review of the "amount of benefits under part A," which, under 42 U.S.C. 1395ff(a), is determined in accordance with regulations issued by the Secretary. As we have said (see page 3, *supra*), judicial review under Part A may include a challenge to regulations that establish benefit amounts or guide fiscal intermediaries in computing those amounts. The corresponding *foreclosure* of judicial review under Part B accordingly must extend to challenges to instructions or regulations issued by the Secretary that have the effect of limiting the amount of benefits determined by a carrier.

[6] As this Court observed in *Ringer* (slip op. 13), the determination by the Secretary whether to promulgate a generally applicable rule to resolve a particular issue, or instead to permit individual adjudication, is a matter committed to the Secretary's discretion. The availability of judicial review under Part B should not turn on whether the Secretary has chosen to promulgate such a regulation or instead left the issue to the carrier to resolve.

op. 3-4; 42 C.F.R. 405.860) and which limited the amount of benefits that could be awarded by the carriers. See *Erika, Inc.* v. *United States*, 634 F.2d 580, 590-591 (Ct. Cl. 1980). This Court nevertheless held that judicial review was foreclosed.[7]

If there could be any doubt remaining on this point after *Erika*, it was dispelled by the decision in *Ringer*. That case involved a challenge to a regulation issued by the Secretary that prohibited the payment of *any* amount of benefits under Medicare for a particular medical service. Slip op. 2-5. Yet the Court held, without dissent, that insofar as the regulation applied to the Part B Program, judicial review of the regulation was barred by this Court's decision in *Erika*. *Ringer*, slip op. 5 n.4. The Court so held even though the plaintiffs in *Ringer*, like respondents herein, did not actually request the Court to award benefits, but instead sought only an invalidation of the regulation that would bind the carrier in its subsequent adjudication of individual claims. Slip op. 9-10, 12. Because the Court in *Ringer* explicitly relied on *Erika*, which in turn relied on the foreclosure of review in 42 U.S.C. 1395ff, the court of appeals in this case was simply mistaken when it stated that "[i]n reaching its decision in [*Ringer*], the Supreme

---

[7] It is worth noting that in *Erika*, the American Academy of Family Physicians, represented by counsel who also represents respondents in this case, filed a brief as amicus curiae. That brief argued extensively that 42 U.S.C. 1395ff should not be read to foreclose regulatory, statutory or constitutional challenges to a carrier's actions, even if review of essentially arithmetic computations of benefit amounts is foreclosed (Amicus Br. at 15-18, 21 n.13, 23, 25-27). The brief also relied upon the district court's decision in the instant case as an example of the sort of statutory challenge to a carrier's actions that, like the claim in *Erika* itself, should not be foreclosed by 42 U.S.C. 1395ff (Amicus Br. at 28). Respondents therefore are attempting in this case to reargue the position that was advanced on behalf of family physicians but was rejected by this Court in *Erika*.

Court did not rely on § 1395ff" (App., *infra*, 18a n.2). And this error might explain the court of appeals' otherwise inexplicable assertion that its jurisdictional holding was not inconsistent with *Ringer* (App., *infra*, 22a).

b. The correctness of the result indicated by 42 U.S.C. 1395ff standing alone—that judicial review of a regulation affecting the calculation of the amount of benefits under Part B is foreclosed because it is not expressly authorized by the Social Security Act—is confirmed by 42 U.S.C. 405(h), which is made applicable to the Medicare Program by 42 U.S.C. 1395ii. The second sentence of Section 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency *except as herein provided*" (emphasis added). This sentence embodies a general rule under the Social Security Act that judicial review is unavailable except where and in the manner such review is expressly authorized by that Act.[8] Because Congress has not affirmatively provided for judicial review under Part B in the Social Security Act itself, the second sentence of Section 405(h) precludes such review.

The third sentence of Section 405(h) further provides that "[n]o action against the * * * Secretary * * * shall be brought under section [ ] 1331 * * * of title 28 to recover on any claim arising under this subchapter." The court of appeals' holding that the district court had jurisdiction in this case under 28 U.S.C. 1331 directly contravenes this jurisdictional bar as well. This conclusion, too, is compelled by *Ringer*. There, the Court held that Section 405(h) barred the bringing of an action under 28 U.S.C. 1331 to challenge instructions issued by the Secretary to fiscal intermediaries and a formal rul-

---

[8] Because carriers make determinations on claims for benefits under Part B on behalf of the Secretary (see *Schweiker* v. *McClure*, 456 U.S. at 190), this preclusion of review applies equally to findings and decisions by the carriers under Part B.

ing (equivalent to a regulation) issued by the Secretary that had the effect of barring the payment of benefits under Medicare for a particular type of surgery. *Ringer*, slip op. 10-12, 16-23. The Court explained that the plaintiffs' assertedly "procedural" challenge to those directives was inextricably intertwined with their substantive claims to benefits and that the challenge therefore could be raised only in an action for judicial review under the Social Security Act itself—pursuant to 42 U.S.C. 405(g), after full exhaustion of administrative remedies. *Ringer*, slip op. 9-12.

The court of appeals' holding in its original opinion in the instant case that Section 405(h) does not bar review because respondents purport to challenge only the "procedure" utilized by the carrier to calculate benefits, not the amount of benefits paid on a particular claim (App., *infra*, 10a), is squarely inconsistent with *Ringer*. Following this Court's remand, the court of appeals recited this controlling aspect of *Ringer* (App., *infra*, 19a-20a), but it nevertheless reinstated its prior opinion finding jurisdiction under 28 U.S.C. 1331 (App., *infra*, 22a), apparently relying once again on the asserted distinction, rejected in *Ringer*, between a challenge to a regulation affecting the amount of benefits and a challenge to a decision on a particular claim for benefits (App., *infra*, 18a-19a, 20a).

The court of appeals also sought in its original opinion to distinguish this Court's decisions construing Section 405(h) on the ground that in *Salfi* and its progeny, judicial review was in any event available under 42 U.S.C. 405(g), whereas if Section 405(h) were read to bar federal question jurisdiction under Part B, judicial review would be entirely foreclosed because 42 U.S.C. 405(g) is not available as an alternative avenue for judicial review under Part B. See App., *infra*, 10a. Thereafter, this Court in *Ringer* explicitly rejected the proposition that the meaning of Section 405(h) somehow shifts de-

pending on whether review is available under Section 405(g). *Ringer*, slip op. 19. Yet on remand after *Ringer*, the court of appeals expressly credited this very argument (App., *infra*, 19a, 20a, 21a).

c. The court of appeals also held on remand that *Ringer* does not bar challenges by "a party other than a claimant for benefits" (App., *infra*, 22a), by which the court apparently meant the physicians who challenged the regulation and charge screens but did not request the court to award benefits. This attempt to distinguish *Ringer* is frivolous. In *Ringer*, one plaintiff had not yet had the BCBR surgery and thus was not in a position to submit a request for benefits to the intermediary. The Court nevertheless held that 42 U.S.C. 405(h) foreclosed the bringing of an action under 28 U.S.C. 1331 to challenge the Secretary's ruling that barred payment for the surgery. *Ringer*, slip op. 16-23. The physicians in this case are in exactly the same position. They could have standing to challenge the regulation authorizing separate charge screens only because they have submitted or will submit assigned claims for benefits that would be affected by those charge screens. Under *Ringer*, the fact that they have not yet done so (if indeed that is the case) does not remove them from the jurisdictional bar in Section 405(h).

It would, moreover, be anomalous indeed for Congress to permit *physicians* to obtain judicial review but to deny such review to *beneficiaries*, who pay premiums to be insured under the Part B Program and therefore are most directly affected by regulations limiting the amount of benefits that may be paid. The Act itself demonstrates that Congress did no such thing. A carrier administering the Part B Program on behalf of the Secretary may make payment to a physician only if the beneficiary has assigned his claim for benefits to the physician. 42 U.S.C. 1395u(b)(3)(B)(ii). Although the Act grants a right of administrative review only to an

"individual enrolled under [Part B]," 42 U.S.C. 1395u(b)(3)(C), the Secretary by regulation has provided that a physician who accepts an assignment stands in the shoes of the beneficiary and has the same right to administrative review by the carrier. 42 C.F.R. 405.801(a); *Erika*, 456 U.S. at 207 n.7. But the assignee physician also is subject to the same preclusion of *judicial* review that applies to the beneficiary. The Court so held in *Erika*. There it was the supplier of Part B services, not the beneficiaries themselves, who sought judicial review.

The foreclosure of review is confirmed by a comparison with the Part A Program. Under Part A, Congress enacted a separate mechanism by which a hospital or other provider may obtain judicial review of the amount of reimbursement it will receive for services it renders to Medicare beneficiaries. 42 U.S.C. 1395*oo*(f)(1); see pages 3-4, *supra*. "In the context of the statute's precisely drawn provisions," the fact that Congress expressly authorized judicial review for providers under Part A, but not for their counterparts under Part B (in this case, physicians), furnishes persuasive evidence that Congress "deliberately intended to foreclose" review in the latter situation. *Erika*, 456 U.S. at 208. See also *Block* v. *Community Nutrition Institute*, No. 83-458 (June 4, 1984), slip op. 6.

d. In the end, the court of appeals was forced to rely on nothing more than a "presumption" in favor of judicial review, believing that "for every right there must be a remedy" (App., *infra*, 22a). But this Court made clear in *Block* v. *Community Nutrition Institute*, *supra*, that "[t]he presumption favoring judicial review of administrative action is just that—a presumption" (slip op. 8)—and that it may be overcome by a consideration of the language, structure, purpose and legislative history of the statute and the nature of the administrative action involved (*id.* at 5, 8-11). When the court of

appeals first ruled, this Court already had held in *Erika* that a congressional intent to preclude judicial review under Part B was "persuasive[ly] evidence[d]" by the text of 42 U.S.C. 1395ff (456 U.S. at 208) and "unambiguously support[ed]" by its legislative history (*id.* at 211). Subsequently, the Court, without dissent, adhered to that view in *Ringer* (slip op. 5 n.4). Needless to say, these holdings should have been sufficient for the court of appeals, on remand after *Ringer*, to overcome the presumption in favor of judicial review.

2. a. The decision of the court of appeals in this case directly conflicts with the Fourth Circuit's recent decision in *Starnes* v. *Schweiker*, 748 F.2d 217 (1984), cert. denied, No. 84-1309 (Apr. 15, 1985). There, the Fourth Circuit, like the Sixth Circuit in the instant case, initially held that 42 U.S.C. 1395ff and 42 U.S.C. 405(h) did not bar federal question jurisdiction over a challenge to directives issued by the Secretary that limited payments for certain Part B services. *Starnes* v. *Schweiker*, 715 F.2d 134 (1983). This Court subsequently vacated the Fourth Circuit's judgment and remanded for further consideration in light of the intervening decision in *Ringer*. *Heckler* v. *Starnes*, No. 83-1149 (June 4, 1984). Faithful to that mandate, the Fourth Circuit on remand held that the suit must be dismissed for lack of jurisdiction. It explained (748 F.2d at 218):

> *Ringer* establishes that we misread *Erika*. *Ringer* decides that Starnes' contention that there were procedural irregularities in the promulgation of the caps [is] so inextricably intertwined with a claim for benefits that any judicial review is barred by 42 U.S.C. § 1395ff.

Similarly here, respondents' challenge to the regulation and the separate charge screens it authorizes is intertwined with the claims for benefits that are affected by those screens, and judicial review therefore is barred by 42 U.S.C. 1395ff. The court of appeals' deci-

sion in this case thus conflicts with *Starnes*. That conflict warrants resolution by this Court.

b. Other courts of appeals, following *Ringer*, have further recognized that "whether a claimant challenges the procedures used by the Secretary to reject a claim or challenges the substantive basis for that rejection, [42 U.S.C.] 405(h) makes [28 U.S.C.] 1331 jurisdiction unavailable." *Ganem* v. *Heckler*, 746 F.2d 844, 848 (D.C. Cir. 1984). See also *American Federation of Home Health Agencies, Inc.* v. *Heckler*, 754 F.2d 896, 897-898 (11th Cir. 1984); *Smith* v. *North Louisiana Medical Review Ass'n*, 735 F.2d 168, 171-172 (5th Cir. 1984). The decision below finding jurisdiction under 28 U.S.C. 1331 over respondents' challenge to the manner in which the carrier calculates the reasonable charge conflicts with these decisions as well.

c. We had assumed that, whatever other jurisdictional issues under the Social Security Act remain unresolved,[9] it at least was firmly established that judicial review under Part B of the Medicare Act is entirely foreclosed (at least in the absence of a constitutional challenge to the Medicare Act itself, cf. *Schweiker* v. *McClure*, *supra*). The Sixth Circuit's ruling in this case does away with that assumption and threatens to reintroduce the regime of uncertainty and widespread litigation on Part B issues that prevailed prior to

---

[9] We have recently sought review of jurisdictional rulings in three cases arising under Title II or Title XVI of the Social Security Act, 42 U.S.C. 401 *et seq.*, 1381 *et seq.* See *Heckler* v. *Owens*, appeal pending, No. 84-1905 (docketed June 5, 1985); *Heckler* v. *City of New York*, petition for cert. pending, No. 84-1923 (filed June 7, 1985); *Heckler* v. *Polaski*, petition for cert. pending, No. 85-55 (filed July 11, 1985).

Erika.[10] This Court should not permit such a disregard of its clear pronouncements.[11]

CONCLUSION

The petition for a writ of certiorari should be granted, and the judgment of the court of appeals should be summarily reversed.

Respectfully submitted.

CHARLES FRIED
Acting Solicitor General
RICHARD K. WILLARD
Acting Assistant Attorney General
KENNETH S. GELLER
Deputy Solicitor General
EDWIN S. KNEEDLER
Assistant to the Solicitor General
ANTHONY J. STEINMEYER
HAROLD J. KRENT
Attorneys

AUGUST 1985

---

[10] Several district courts likewise have failed to follow *Ringer* in Part B Medicare cases, thereby underscoring the potential for such litigation. See, *e.g.*, *National Association of Patients on Hemodialysis & Transplantation, Inc.* v. *Heckler*, 588 F. Supp. 1108, 1115-1118 (D.D.C. 1984); *Bio-Medical Applications of Providence, Inc.* v. *Heckler*, 593 F. Supp. 1233, 1235-1236 (D.D.C. 1984), appeal pending, No. 84-5802 (D.C. Cir.); *Linoz* v. *Heckler*, 598 F. Supp. 486 (D. Hawaii 1984), appeal pending, No. 84-2446 (9th Cir.).

[11] Because the district court clearly was without jurisdiction in this case, we have not sought review of the court of appeals' decision on the merits. However, for the reasons stated in our previous petition for a writ of certiorari in this case (84-120 Pet. 12 n.5), it is our view that the court of appeals' invalidation of the relevant regulation, which was promulgated only one year after the Medicare Program went into effect, was plainly incorrect. We shall not repeat that discussion here.

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN

[Filed Feb. 23, 1984]

Before: JONES, Circuit Judge; PECK and BROWN, Senior Circuit Judges.

PECK, Senior Circuit Judge. The principal question raised in this appeal is the validity of the method adopted by the Department of Health and Human Services (HHS) by which certain eligible individuals receive reimbursement for services performed by physicians and other individuals pursuant to the federal Health Insurance for the Aged and Disabled Act (Medicare), 42 U.S.C. § 1395 *et seq.* The Michigan Academy of Family Physicians (Michigan Academy) filed suit against Blue Cross and Blue Shield of Michigan (BC/BSM) and Richard S. Schweiker, Secretary of HHS (Secretary). The complaint alleges that the classification of certain family physicians separately from other physicians with

similar qualifications, and together with non-allopathic doctors (such as chiropractors and podiatrists), contraverted the statutory mandate of Congress as expressed in the Medicare Act. A violation of due process and equal protection rights under the fifth amendment of the United States Constitution is also claimed. The district court, after finding jurisdiction, held that the classification violated the Medicare Act, §§ 1395u(b)(3) & 1395a, and ordered the Secretary to include all family physicians with other medical doctors. BC/BSM and the Secretary appeal.

BACKGROUND

The Medicare Act consists of two programs. Part A provides insurance for hospitalization and post-hospital services. 42 U.S.C. § 1395c-1395i-2. Part B, at issue in this case, provides insurance for supplemental medical care. 42 U.S.C. § 1395j-1395w. Under part B eligible individuals may voluntarily enroll in the health insurance program by paying a monthly premium. Members enrolled in the program may request reimbursement of eighty per cent of the reasonable charges, as defined by the insurance carrier, of the services rendered, or assign the right of reimbursement to their physician, 42 U.S.C. § 1395u(b)(3)(B)(ii).

As directed by statute, the Secretary is required to contract with an insurance intermediary to administer the Medicare part B program. 42 U.S.C. § 1395u. According to statute, the carrier is responsible for determining reasonable fees for covered services in order to calculate the applicable reimbursement amount. *Id.* The Act further provides that a carrier, in calculating these reimbursements, is to consider "the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services." 42 U.S.C. § 1395u(b)(3). Price ceilings are placed on the calculation of the reasonable fee so that such fee is not

reasonable if it exceeds either the prevailing or customary fees as calculated under the Medicare Act.[1]

In August, 1967, the Secretary validly promulgated 42 C.F.R. § 405.504. 32 Fed. Reg. 12600 (1967). After first restating the definition of prevailing charges, the regulation in part B permits carriers to establish separate prevailing charges for "specialists" and "non-specialists" and specifically provides that carriers can develop more than one set of prevailing charges based on fee patterns in a local area. As a practical result of this regulation, carriers developed separate and distinct prevailing charges for different types of physicians. Under the regulation, patients receiving one type of service from a specialist are entitled to incur a higher reasonable charge, and therefore to receive a larger reimbursement than if they received the identical service from a non-specialist.

---

[1] 42 U.S.C. § 1395u(b)(3) provided a complex methodology for calculating the specific amounts of each category. The section provides in pertinent part:

> In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made....

FACTS

Beginning in 1966 the Secretary contracted with BC/BSM to administer the Medicare part B program in the state of Michigan. BC/BSM, in initially determining charges, lumped physicians into three groups for the purpose of calculating prevailing charges in each geographic locality in Michigan. One group consisted exclusively of hospital internists and other hospital specialists. A second group consisted of certified specialists. The final group consisted of general practitioners and other non-specialists. Thereafter, with the passage of 42 U.S.C. § 1395x(r), including other non-allopathic doctors such as chiropractors, dentists, and podiatrists in the Medicare Program, BC/BSM restructured its prevailing charge screens, devising the present system. Group 1 consisted of hospital personnel and other internists. Group 2 consisted of specialists and board certified specialists or board eligible specialists. Group 3 included general practitioners, board eligible family physicians, and other non-physicians added in the 1972 amendment to the Medicare statute.

Under the Medicare system existing in Michigan, and in several other states, a physician determines what services he will perform for a patient. If covered by the Medicare Act, he assigns the service a procedural code or number from those denoted by the Secretary. BC/BSM, after determining what type of physician performed the service, will thereupon reimburse the patient, or his assignee, based in part on the prevailing charge screen within which the physician is classified. In practice, enrollees receiving services from a specialist would receive a larger reimbursement amount than if they received similar services from a general practitioner performing the same service.

The Michigan Academy, a nonprofit Michigan corporation representing family physicians throughout the state, filed suit against BC/BSM and the Secretary,

arguing that the Michigan reimbursement procedure violated the Medicare statute and was unconstitutional. It alleged that the use of prevailing charge screens ignored the Medicare Act's mandate to reimburse equal amounts for similar services performed. Further, Michigan Academy alleged, the use of prevailing charge screens had an impermissible impact on an enrollee's choice of a physician and unduly infringed the free practice of medicine. Alternatively, Michigan Academy argued that the procedure denied its members equal protection and due process under the fifth amendment of the United States Constitution since 42 C.F.R. § 405.504 irrationally classified them together with nonallopathic doctors rather than with other specialists with whom they shared similar qualifications and talents.

At trial no witness for Michigan Academy or BS/BSM could explain why family physicians were separately categorized from all other medical specialists. BC/BSM, in addition, indicated that its classifications were not based on any particular statistical data but that they had apparently evolved over the years.

At the close of all the evidence, the district judge held that § 405.504 violated the Medicare Act. He found that the Medicare Act mandated equal reimbursements for similar services performed despite the type of physician performing them, and that the prevailing charge screens improperly infringed on a patient's free choice in selecting a physician. At the same time, while indicating on several occasions that he felt the regulation was irrational and without support in the trial record, the district judge specifically refused to rule that the regulation is unconstitutional. Holding only that the regulation violated the Medicare Act, the district judge ordered the Secretary to reclassify all physicians together, including family physicians, in one single prevailing charge screen.

On appeal, BC/BSM and the Secretary argue initially that the district court lacked jurisdiction to render its decision. In the alternative, they contend that § 405.504 is a permissible interpretation by HHS of the language of the Medicare Act and that the classification of certain family physicians is constitutional. Even if this court disapproves § 405.504 and finds it unconstitutional, BC/BSM and the Secretary argue, the district judge's remedy of restructuring the prevailing price screens was improper. The court, they contend, should remand the case to the Secretary to allow for a proper restructuring of the reimbursement procedure.

JURISDICTION

We initially turn to the thorny question of whether the district court had jurisdiction to render a decision in this case. In its brief BC/BSM contends that § 205(h) of the Social Security Act, 42 U.S.C. § 405(h), as interpreted by the courts, precludes jurisdiction in this case. BC/BSM first characterizes this cause as a dispute over the amount of reimbursements owed a recipient under the Medicare part B program, an area in which Congress specifically foreclosed judicial review. Since § 1395ff provides a complex administrative methodology for resolving such appeals, BC/BSM urges, no judicial review of such matters is available. In the alternative, they contend that even though § 1395ff is silent on the question of judicial review of decisions by the Secretary made in the course of implementing the Medicare part B program federal question jurisdiction under 28 U.S.C. § 1331 is specifically precluded by § 405(h).

It is well-settled that there is no judicial review of disputes simply concerning the amount of reimbursement or an individual's eligibility to receive Medicare part B benefits. The Supreme Court in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), interpreting 42

U.S.C. § 1395ff,[2] held that Congress clearly and convincingly intended that no judicial review of such questions was permissible. The Court found that the legislative history of § 1395ff, as well as the presence of an elaborate administrative review mechanism, clearly showed Congress's intent to bar such disputes from judicial consideration. Id. at 208-09. Among the numerous concerns Congress had mentioned and the Court found important was the need to stem the potential avalanche of litigation concerning the amount of reimbursement. *Id.* In finding that no federal question jurisdiction existed for adjudicating questions involving the amount of reimbursements under Medicare part B, the Supreme Court left open the question of whether all claims in-

---

[2] Section 1395ff provides in pertinent part:

> (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b)(1) Any individual dissatisfied with any determination under subsection (a) as to—
>
> (A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title, or section 1818, or section 1819, or
>
> (C) the amount of benefits under part A (including a determination whether such amount is determined to be zero)
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).
>
> (2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000....

volving disputes over the administration of part B reimbursements were similarly foreclosed.

In the wake of *Erika*, however, courts have strenuously endeavored to find jurisdiction over various types of challenges to the procedural aspects of the Medicare part B program despite the language of § 1395ff. The Supreme Court itself permitted a constitutional challenge to the hearing process which Congress permitted under § 1395ff. *Schweiker* v. *McClure*, 456 U.S. 188 (1982). Other federal courts have followed suit. *Colonial Penn Insurance Co.* v. *Heckler*, 721 F.2d 431 (3d Cir. 1983); *Starnes* v. *Schweiker*, 715 F.2d 134 (4th Cir. 1983); *Ringer* v. *Schweiker*, 697 F.2d 1291 (9th Cir. 1982), *cert. granted sub nom. Heckler* v. *Ringer*, 103 S. Ct. 3535 (1983).

In this case BC/BSM contends this suit involves simply a dispute over the amount of reimbursement due. In a word, BC/BSM contends, Michigan Academy simply is seeking to have family physicians and their patients moved to the more lucrative specialist screen, boiling down to an argument for an increase in amounts reimbursed. *Erika*, it concludes, should bar this suit outright. This argument, however, is without merit.

While the eventual result of this suit may cause an increase in amounts of reimbursement, that does not necessarily follow. In some cases the result might be an increased amount of reimbursement, and in others, a reduction in reimbursement could occur. Michigan Academy, at bottom line, is challenging the overall mechanism for determining the amounts of reimbursements, not the actual value of any particular reimbursement.

More importantly, unlike the situation in *Erika*, *supra*, there is no indication that Congress intended to preclude our jurisdiction over suits challenging procedural aspects of the Medicare program, despite the language of § 1395ff or § 405(h). Section 1395ff, by its

terms as interpreted by the Supreme Court, precludes judicial review of decisions by the carrier concerning amounts of reimbursements, but is silent on the question of reviewing decisions of the Secretary made in implementing the overall Medicare part B program. *Erika, supra; Starnes, supra.* At the same time, Congress provided for an elaborate administrative review of the carrier's decisions. *See* 42 U.S.C. § 1395ff(a). No similar procedure was developed for review of disputes such as that raised in this case. This court has pointed out that where no mechanism for reviewing administrative decisions is available, courts should be slow to find Congress intended such a bar absent a clear and convincing showing either in the particular act's language or legislative history. *Chelsea Community Hospital, SNF* v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1134 (6th Cir. 1980) (citing *Association of Data Processing Service Organizations* v. *Camps*, 397 U.S. 150 (1970) and *Abbott Laboratories* v. *Gardner*, 387 U.S. 136 (1967)) (jurisdiction exists for reviewing pre-1973 claims disputing the amount of reimbursement under part A of the Medicare Act where no other mechanism for review of such determinations available). With this in mind, we hesitate to bar judicial review over this suit simply because Congress failed to specifically allow for our review in § 1395ff.

BC/BSM and the Secretary argue, however, that even if the language of § 1395ff does not specifically foreclose our review in this case, 42 U.S.C. § 405(h), as incorporated into the Medicare Act by 42 U.S.C. § 1395ii, provides clear support for the contention that Congress intended to preclude all judicial review. They contend that the Supreme Court specifically held that no jurisdiction existed for claims arising under the Social Security Act based on the clear and unambiguous language of this section. *Weinberger* v. *Salfi*, 422 U.S. 749 (1975) (where no other jurisdiction was provided

under the Social Security Act, no judicial review could lie). Since this precise provision was incorporated into the Medicare statute, they argue, and § 1395ff does not specifically provide for judicial review of part B claims, it should be similarly construed in this case. We disagree.

In *Salfi*, *supra*, the Supreme Court specifically referred to the alternative methods available for judicial review of Social Security disputes. *Id.* at 757 (jurisdiction available under § 405(g)). Later Supreme Court decisions have readily followed *Salfi* in barring federal question jurisdiction, but at the same time permitted suits under § 405(g). *Califano* v. *Yamasaki*, 442 U.S. 682, *remanded sub nom. Yamasaki* v. *Harris*, 607 F.2d 329 (9th Cir. 1979); *Mathews* v. *Eldridge*, 424 U.S. 319 (1976).

In *Herzog* v. *Secretary of HEW*, 686 F.2d 1154 (6th Cir. 1982), this court, while barring judicial review of statutory challenges to amounts of reimbursement under part B of the Medicare Act, specifically referred to the elaborate administrative mechanism of § 1395ff as an alternative avenue of review. The court in *Herzog* pointed out that Congress intended to direct such disputes through administrative process rather than overload the federal courts with a flood of small claims. *Id.* at 1158. *See also Erika*, *supra*; *Starnes*, *supra*.

Unlike *Herzog*, however, this dispute involves not a challenge to an individual amount of reimbursement, but instead a challenge to a regulation by the Secretary establishing the procedure under which reimbursement schedules should be determined. Further, Congress did not provide any mechanism to review such decisions of the Secretary in this type of case. In the absence of federal question jurisdiction, therefore, the Secretary apparently would have unbridled discretion to promulgate any regulation he chose. Courts confronted with this dilemma have held that Congress did not intend to pre-

clude federal jurisdiction over such causes. *Colonial Penn Insurance Co., supra; Starnes, supra; Ringer, supra. Cf. Chelsea Community Hospital, supra* (court will entertain suit where no means of reviewing pre-1973 reimbursements under part A of Medicare Act and nothing to indicate Congress intended to foreclose such jurisdiction). Given the presumption favoring judicial review and absent a clear and convincing showing that Congress intended the contrary,[3] we conclude that the district court correctly found federal question jurisdiction under 28 U.S.C. § 1331 to render a decision in this case.

STATUTORY CHALLENGE

Having determined that the district court properly exercised jurisdiction, we turn to the question of whether the Secretary's method of determining reasonable charges for calculating the amount of reimbursements under part B of the Medicare Act in the state of Michigan conformed with the statutory directives of 42 U.S.C. § 1395u(b)(3). After careful analysis of the Medicare Act, its legislative history, and the procedure selected by the Secretary, we find the present methodology impermissible.

Devising procedures for calculating reasonable charges for purposes of reimbursements § 1395u(b)(3) of the Medicare Act specifically requires the Secretary to focus on the customary and prevailing charges for similar services in a locality. The obvious common denominator throughout § 1395u(b)(3) is "similar services." Though not defined by the statute, the language plainly stands for the proposition that once a particular service is determined, all services of a similar nature are to be compensated or reimbursed at the customary,

---

[3] *Chelsea Community Hospital, SNF v. Michigan Blue Cross Ass'n, supra* (citing *Ass'n of Data Processing Service Organizations v. Camp, supra; Abbott Laboratories v. Gardner, supra*).

or prevailing rate. The touchstone of this language is that similar services, once determined, are to be compensated equally, regardless of who performs them, at a particular level, determined by the carrier. *See* 42 U.S.C. § 1395u(b)(3); *Alexander* v. *Schweicker* [*sic*], 516 F. Supp. 182 (D. Conn. 1981).

Despite this plain statutory language and without explanation, the Secretary promulgated 42 C.F.R. § 405.504 providing that carriers, in calculating prevailing charges for a particular locality, could develop separate prevailing charges for physicians who were specialists. Such prevailing charges, as defined in § 405.504(2) were to be based on statistics, reflecting customary charging patterns in the locality. In implementing this program in Michigan, the Secretary approved BC/BSM's plan of lumping physicians and non-physicians into three categories, separating specialists from non-specialists except in the case of family physicians. Under this approach, once a physician or other medical provider selected a particular service to perform he chose the appropriate procedure code for the service. Reimbursement for that service was then determined on the basis of the charge screen to which the particular physician or non-allopathic doctor was assigned. Under this approach, a general practitioner would receive a smaller sum than would a specialist for a routine office visit, despite their selections of identical procedural codes.

BC/BSM and the Secretary in an effort to reconcile the obvious inconsistency between the language of § 1395u(b)(3) and the regulation, argue that § 405.504 attempts to further the legislative intent to have reimbursements under the Medicare Act reflect actual charging patterns in the community. They refer to several instances where Congress stated its concern about the possibility of artificially distorting fees charged by physicians through undue interference with physicians'

fees. At trial, however, when questioned about the statistical basis of the Michigan prevailing charge screens, particularly in the separation of family physicians from all other medical specialists (even though they have similar qualifications and perform similar services), no witness could produce actual data demonstrating the significance of such a division. Dr. Boyles, testifying at the trial, stated that the statistical evidence supporting the entire plan was at best "skimpy".[4] Nor could witnesses point to any actual evidence demonstrating that family physicians and non-physicians, such as chiropractors or podiatrists, charged similar amounts for similar services. In fact, the record indicated that the revisions of the prevailing charge screens in 1973 were primarily based on the evolution of the original set of screens which had been basically selected without the benefit of actual data.

We recognize the fact that regulations promulgated by the Secretary must be granted deferential consideration and that we should exercise caution in overturning them. *NLRB* v. *Bell Aerospace Co. Division of Textron, Inc.*, 416 U.S. 267, 274-75 (1974). In this case, in addition to there being no justification for its promulgation, and the obvious inconsistency with the plain language of the Medicare statute, we also hold that this regulation is irrational and is invalid.[5]

Our decision to invalidate the regulation is bolstered by the district court's findings concerning the pernicious impact of this system on the cost of medical care.

---

[4] Paul Riesel, Chief of the Physician Practitioner Reimbursement Branch in the Bureau of Program Policy of the Health Care Financing Administration in Baltimore, Maryland, stated that no instructions were given to the carriers for determining prevailing charges and there was no apparent reason for separating family physicians from other specialists with similar qualifications.

[5] Having found this regulation statutorily unsound, we need not address the constitutional issues also raised in this case.

Several witnesses, including former Secretary of HEW Joseph A. Califano, pointed to the severe inflationary impact the system produced. In addition, due to more lucrative reimbursements of specialists, doctors had an added incentive to become specialized and over-utilize technology leading to increased medical costs. At the same time the system, by encouraging specialization, forced patients to seek specialists even for routine health care. Primary care, at the same time, tended to fall off as more and more doctors entered specialty fields. In passing the Health Professions Educational Assistance Act of 1976, Congress clearly expressed its concern for the continued need to protect and encourage primary medical care. *See* Pub. L. No. 90-484, 90 Stat. 2243 (reference to congressional intent to improve maldistribution of physicians and improve availability of primary health care). As was plainly demonstrated at trial, the maldistribution of physicians was significantly enhanced through the use of prevailing charge screens. As a corollary to our holding, therefore, we conclude that these findings by the district court are sufficient to support its determinations that the regulation as applied violates 42 U.S.C. § 1395a, prohibiting infringement of a patient's free choice of a physician.

While we hold today that 42 C.F.R. § 405.504 is invalid, due to its failure to recognize the statutory mandate that similar services be considered identically regardless of who performs them, we think the district court's remedy, adopting sua sponte a single prevailing charge screen for all physicians, goes too far. In a case as complex as this one, we seek the expertise of the government agency to which Congress has assigned responsibility for implementing the statute. Our function on review must be one that is clearly limited to providing correct guidelines within which the knowledge and experience of the specialized agency is called into play. In so doing the policies and goals of the statute may

more closely be pursued and implemented. *Industrial Union Dept.* v. *American Petroleum Institute*, 448 U.S. 607 (1980); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976).

We therefore remand this case to the Secretary for reconsideration of the Michigan reimbursement plan under part B of the Medicare program with instructions to consider similar services in an equal manner regardless of who performs that service.

Remanded.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS.

[Filed Nov. 5, 1984]

ORDER

Before: JONES, Circuit Judge; PECK and BROWN, Senior Circuit Judges.

This case is before this court on remand from the Supreme Court of the United States. The Supreme Court, after granting certiorari, vacated the judgment of this court and remanded for reconsideration in light of *Heckler* v. *Ringer*, 104 S. Ct. 2013 (1984), which was announced subsequent to the filing of our opinion herein.

We conclude that the principles stated by the Supreme Court in *Heckler* v. *Ringer* require us to find that the federal courts lack jurisdiction over the present case, and therefore remand the cause to the United States District Court for the Eastern District of Michigan with instructions to dismiss.

It is so ordered.

ENTERED BY ORDER OF THE COURT

/S/ John P. Hehman

JOHN P. HEHMAN

Clerk

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL. PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS.

[Decided and Filed March 19, 1985]

ORDER

Before: JONES, Circuit Judge; PECK and BROWN, Senior Circuit Judges.

I. Prior Decision and Present Posture of the Case.

In our initial opinion herein, 728 F.2d 326 (6th Cir.), *vacated and remanded,* 105 S.Ct. ___ (1984), we held that a regulation promulgated by the Secretary of Health and Human Services ("Secretary"), 42 C.F.R. § 405.504, violated the language of the Medicare Act as set forth at 42 U.S.C. § 1395u(b)(3) (reimbursement if for "similar services"). In reaching this decision, we held that the district court (and this court) had jurisdiction to hear the challenge brought by the plaintiff, Michigan Academy. Our opinion stated that the challenge to the regulation was based on both statutory and constitutional grounds and was not simply "a challenge to an individual amount of reimbursement." 728 F.2d at 331.[1]

---

[1] Michigan Academy contended that the regulation, which authorized Medicare providers such as Blue Cross to set distinct pre-

Following consideration of the remand by the Supreme Court, we entered a similar order remanding the case to the district court for reconsideration in the light of *Heckler* v. *Ringer*, 466 U.S. ___, 104 S.Ct. 2013 (1984). Appellees thereupon petitioned for reconsideration of our remand order, and it is that petition, accompanied by extensive briefs, which is presently before us.

The only issue relevant on remand is that of jurisdiction. In the prior decision we held that federal question jurisdiction existed to hear the challenge under 28 U.S.C. § 1331. As an initial point, we rejected the contention that 42 U.S.C. § 1395ff, which authorizes administrative review of eligibility determinations under Part B of the Medicare Act, implicitly limited review in the federal courts.[2]

We went on to hold that 42 U.S.C. § 405(h), as incorporated in the Medicare Act by 42 U.S.C. § 1395ii, did not specifically prohibit judicial review of a statutory or constitutional challenge to a regulation promulgated under the Medicare Act. 728 F.2d at 330-31. In reaching this decision we distinguished *Weinberger* v. *Salfi*, 422 U.S. 749 (1975) (claims arising under Social Security Act can be reviewed only under § 405(g) procedures) and *Herzog* v. *Secretary*, 686 F.2d 1154 (6th Cir. 1982) (no judicial review for statutory challenges to amount of reimbursement under Part B). 728 F.2d at 331. The basis for the distinction was two-fold: (1) the challenge mustered by Michigan Academy involves not an amount

---

vailing charges for identical services when performed by different types of physicians, was contrary to the Medicare Act as well as violative of the Equal Protection and Due Process Clauses of the Constitution.

[2] In reaching its decision in *Heckler* v. *Ringer*, *infra*, the Supreme Court did not rely on § 1395ff. *See United States* v. *Erika, Inc.*, 456 U.S. 201 (1982) (only review of eligibility issues under Part B of Medicare Act is provided by § 1395ff).

of reimbursement but the promulgation of a regulation; and, (2) a contrary decision would preclude any judicial review.

II. Hecker v. Ringer.

In *Ringer, supra*, the Supreme Court, construing § 405(h) as incorporated in the Medicare Act, held that § 405(g)—to the exclusion of 28 U.S.C. § 1331 (federal question jurisdiction)—"is the sole avenue for judicial review for all 'claim(s) arising under' the Medicare Act." Slip op. at 11 (*citing Salfi*, 422 U.S. at 760-61). The court stated that the "claim arising under" language should be construed quite broadly as applying to claims in which "both the standing and the substantive basis for the presentation" of the claim is the Medicare Act. Slip op. at 11-12 (noting that in *Salfi* a constitutional challenge to the statute had been construed as "arising under" the Social Security A[illegible], although in some sense it had also arisen under the Constitution, the "substantive" claim was for benefits).

Ringer is factually distinct from the instant case. *Ringer* involved two sets of claimants for benefits under Part A of the Medicare Act. The claimants sought reimbursement for bilateral carotid body resection; one group had already had the surgery and was requesting reimbursement, while the other group was comprised of individuals who desired but had not had the surgery. The Secretary had issued, however, an administrative instruction that no Medicare payment was to be made for this surgery to relieve respiratory distress. The claimants claimed that the instruction (and a subsequently promulgated regulation to the same effect) was contrary to statute and the Constitution. The group that had had the surgery had not fully exhausted the administrative remedy afforded by § 405(g).

In addition to holding that § 405(g) is the sole avenue for judicial review of claims arising under the Medicare Act, the Court held that the "claims" of both groups

"arose under" the Medicare Act. The Court rejected a distinction between the "substantive claim" for benefits and the "procedural challenge" and held that the procedural claims were "inextricably intertwined" with the claims for benefits. Slip op. at 9-11.

The Court finally considered whether claimant Ringer, who had not yet had the surgery and "did not yet have a 'claim' to present to the Secretary" was barred by § 405(h)'s "claim arising under" bar. The Court held that a "claim for future benefits must be construed as a 'claim arising under' the Medicare Act...." Slip op. at 18-19.

On October 1, 1984, the Supreme Court vacated and remanded our decision herein for reconsideration in light of *Ringer*.

III. Issue on Remand

Did the Supreme Court's decision in *Ringer* dictate a determination that a group of physicians who are not seeking Medicare Part B benefits have no avenue of judicial review?

IV. Discussion

A. Position of Michigan Academy

The principal argument made by Michigan Academy is that *Ringer* is inapplicable to a challenge by Medicare providers to a regulation promulgated by the Secretary, rather than challenging the existence of a payment or a payment level by a Medicare claimant. Michigan Academy notes that a § 405(g) administrative review was not available to it, as it is to individual claimants. Consequently, in the absence of federal question jurisdiction, it has no opportunity for judicial review, a result that is claimed to raise serious constitutional questions.

Although Michigan Academy does not phrase its position in precisely this form, it seems apparent that it is arguing that the challenges it raises on statutory and constitutional grounds are not "claims arising under"

the Medicare Act for purposes of § 405(h). The issue thus created is whether "claims" are limited to substantive requests or apply more broadly to any challenge. Michigan Academy notes that the Supreme Court has itself exercised federal question jurisdiction to hear a constitutional challenge to the administrative review process provided for the Social Security Act. *Schweiker* v. *McClure*, 465 U.S. 118 (1982).

Michigan Academy finally notes that Judge Kinneary, United States District Court for the Southern District of Ohio, subsequent to *Ringer*, held that *Ringer* did not foreclose judicial review to challenges to the Medicare Act where the challenge was advanced by a party other than a claimant for benefits. *Good Samaritan Medical Center* v. *Heckler*, ___ F. Supp. ___ (1984). Michigan Academy contends that this analysis is accurate and should be followed.[3]

B. The Response of the Secretary

The position of the Secretary is that Michigan Academy cannot obtain judicial review of its claims because under *Erika* and *Ringer* judicial review for claims arising under the Medicare Act exist only where there is an explicit grant of jurisdiction. The Secretary cites footnote 4 of *Ringer* as controlling and compelling dismissal of Michigan Academy's action because the Supreme Court rejected the individual Part B claims, even when characterized as collateral constitutional challenges, as more than a claim for benefits. The Secretary argues that the claim of Michigan Academy is, in reality, a claim for benefits.

The Secretary also argues that Michigan Academy's claim that the absence of judicial review is contrary to constitutional principles was rejected by the Supreme Court when it held that *Salfi* did not stand for the principle that § 405(h) must be construed in light of

[3] An appeal to this court has been perfected.

whether jurisdiction exists under § 405(g). The Secretary next argues that there are alternative means of review: (1) a claimant could seek a higher rate for payment to a family physician; (2) Michigan Academy can petition for amendment or repeal pursuant to 5 U.S.C. § 553(e); (3) the Secretary reviews the performance of carriers such as Blue Cross; and (4) the Secretary on occasion reviews an individual determination.

V. Conclusion

The narrow issue before us is one of first impression and presents a close question. The contra arguments of the Secretary are not unpersuasive, but we incline to the time-honored view that a right cannot exist in a vacuum and that for every right there must be a remedy. As we said in our earlier opinion herein, "Given the presumption favoring judicial review and absent a clear and convincing showing that Congress intended the contrary, we conclude that [federal question jurisdiction exists under 28 U.S.C. § 1331]." 728 F.2d at 331. We further conclude, as did Judge Kinneary in *Good Samaritan Medical Center* v. *Heckler, supra,* that the Supreme Court in *Heckler* v. *Ringer, supra,* did not proscribe judicial review to challenges to the Medicare Act where the challenge was made by a party other than a claimant for benefits.

Since for the reasons herein above set forth we conclude that the opinion of the Supreme Court in *Heckler* v. *Ringer, supra,* is not inconsistent with our opinion, the petition for rehearing is granted and it is hereby ordered that our order of November 5, 1984 remanding this cause to the district court with instructions to dismiss be, and it hereby is, rescinded, and that the opinion of this court filed February 23, 1984, 728 F.2d 326, be and it hereby is reaffirmed.

ENTERED BY ORDER OF THE COURT
John P. Hehman, Clerk
/s/ JOHN P. HEHMAN

APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Civil Action No. 76-72082
MICHIGAN ACADEMY OF PHYSICIANS, A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D., GLENN W. HOUSE, M.D., LESTER WEBB, M.D. AND CAROL A. DIEDRICH, PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, AND PATRICIA HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS

[Filed Dec. 30, 1980]

OPINION

This is an action by plaintiffs seeking judicial review of the action of the Secretary of Health and Human Services in setting reimbursement rates at different levels for certain groups of physicians under Title XVIII of the Social Security Act, Part B, 42 USC 1395, et seq.

Plaintiffs are the Michigan Academy of Family Physicians, a voluntary non-profit association of family physicians, three individual family practitioners, and a Medicare beneficiary.

Defendants are Blue Cross/Blue Shield of Michigan (BC/BSM) a Michigan non-profit corporation which has been designated as the fiscal intermediary and carrier under the Medicare Act for the State of Michigan and

the Secretary of Health and Human Services, the Administrator of the Medicare Program (The Secretary).

At issue is the legality of treating certain family physicians differently from all other physicians in reimbursing them for medical services under Medicare. Such discrimination is illegal for the reasons stated below.

The American Board of Family Practice was established in 1969, and from 1969 until mid-1978 a physician could be qualified to sit for examination by the American Board of Family Practice if he or she had completed a three-year residency program, or if he or she had practiced for a period of six years and completed a minimum of 50 hours continuing education for each of the six years. Effective July 1, 1978, a physician, to be qualified to sit for examination by the American Board of Family Practice, had to have completed a three-year residency program, and, in addition, to take the certification examination. To continue to be board certified, one must retake the examination every six years, and to be either board certified or board eligible one must pursue 50 hours of continuing medical education.

Federal health insurance for the aged, popularly known as Medicare, was enacted by the Congress in 1965, and amended in 1970. The system contains two substantially distant parts, one providing insurance for hospital and related post-hospital services, known as Part A, 42 USC 1395c-1395i-2 (Supp V), the other providing insurance for supplementary medical services, primarily physicians' services, known as Part B. This litigation concerns only Part B of the Medicare Act.

Part B of the Medicare Act is a voluntary health insurance program which operates in a manner similar to private health insurance programs. Eligible individuals enroll in the program and agree to pay a monthly premium established by the Secretary, 42 USC 1395r (b) and (c). The premiums, together with amounts contrib-

uted by the federal government, are deposited in the Federal Supplementary Medical Insurance Trust Fund, which is wholly distinct from the Fund established for Part A. 42 U.S.C. 1395t.

The Medicare Statute provides that Medicare beneficiaries are entitled to reimbursement for medical services provided in the amount of 80 percent of the physician's reasonable charge for covered health services. 48 USC 1395*l*(a)(1)(B). 42 USC 1395u defines "reasonable charge" as the lower of the charges a physician customarily charges for the same service and the prevailing charge in the community for that service. The prevailing charge is statutorily defined as an amount which is equal to the seventy-fifth (75th) percentile of the charges for the same service by other physicians in the same locality.

An individual under Part B who obtains a covered service can pay for this service and request reimbursement at the rate of 80 percent of the "reasonable charge," or assign the right to reimbursement to the person providing this service, who can collect as an assignee of the beneficiary, 42 USC 1395u(b)(3)B(ii). By accepting assignment, a physician agrees to demand no more of a patient that [*sic*] the reasonable charge determined by the Secretary. Accordingly, the patient is only responsible for the 20 percent of the reasonable charge not paid for by Medicare. A physician who does not accept assignment has no statutory limitation on the amount he or she may charge a Medicare beneficiary. However, the physician may not bill Medicare directly, but rather must recover directly from the beneficiary for the services performed.

Upon the inception of the Medicare program, and to this day, BC/BSM has neither developed a procedure to determine what types of professional services are similar to others for purposes of establishing prevailing charges in accordance with 42 USC 1595u(b)(3), nor

carried out a statistical study to determine different types of providers' actual charge patterns for particular services, pursuant to 42 C.F.R. § 405.504(b). Instead, BC/BSM in 1966 established three "screens" to determine the prevailing fee calculations for Medicare "reasonable charge" determination in Michigan. One screen contained board certified and board eligible internists for hospital visits; another screen contained board certified and board eligible specialists, and board certified and board eligible internists for services other than inpatient hospital visits; and the third screen consisted of board certified and board eligible family physicians, nonboard eligible family physicians and various nonphysician groups, such as podiatrists, chiropractors, and dentists.

In February 1973, BC/BSM redefined the three screens. The screens, as they still exist today, were realigned as follows: Screen one is for general practitioners or nonspecialists. Included in this screen are DOs and MDs who are general practitioners, non-board certified family practitioners, chiropractors, podiatrists, and dental surgeons. Screen two is made up of internists for inpatient hospital services only. Contained in this screen are DOs and MDs who are board certified and non-board certified internists for inpatient hospital services only. Screen three is a specialists' screen. It is made up of DOs and MDs who are board certified family practitioners, and board certified and non-board certified specialists. Physicians who engage in a group practice, and who agree to bill under a group number, are placed within the specialists' screen for purposes of determining reasonable charges in Michigan, regardless of the qualification of the physicians in the group.

From these three groupings, a 75th percentile was established, and thus, in determining the prevailing fee for an office visit, the charges of all the physicians

within the so-called "specialty screen" would be lumped together to determine the "reasonable charges." Once a physician is classified as either a specialist or a non-specialist by the carrier, all billings submitted for all types of procedures performed by that physician are priced against prevailing charges applicable to the screen in which he or she is placed. The significance of this procedure with respect to the present case is that the 1973 modification of the screens placed board-certified family physicians in the so-called specialists' screen. Family physicians who were not board certified, whether or not they had completed a certified residency program in family practice, remained in the GPN, or non-specialty screen. These family physicians constitute the only physicians not placed within a specialists' screen, and they are the only physicians whose reasonable charges are determined in part by the charges of non-physicians, such as podiatrists and chiropractors.

At issue is the validity of prevailing charge screens used by BC/BSM as an upper limit on reimbursable charges for physicians' services under Part B.

Plaintiffs claim that there is no factual basis whatever to justify treating family physicians differently from all other physicians, and not only does the discrimination against them have no rational basis theoretically, it makes less sense in application. Even defendants have admitted at trial that there is no rationale for treating board eligible family physicians as non-specialists. Plaintiffs further contend that the change from a dual screen prevailing fee concept to a one screen prevailing fee concept would result in a lower payment for services, render the Medicare Program more efficient, and would more correctly bring into play market forces.

Plaintiffs contend that the creation and maintenance of special family physician differentials for purposes of

determining reasonable charges violates the Fifth Amendment, that the maintenance of the dual reimbursement screen violates plaintiffs' right to procedural due process in that it deprives the plaintiffs of property rights based upon an irrebuttable presumption that plaintiffs' physician services are worth less than, and are not similar to, all other physician services, presumptions not necessarily nor universally true in fact; and that defendants' creation and maintenance of separate reimbursement screens, whereby family physicians are segregated from all other allopathic physicians for determination of Medicare reimbursement violates the express provisions of 42 USC 1395u(b)(3) and the applicable regulations, 42 C.F.R. 405.504(b).

Indeed, the evidence bears out plaintiffs' contention. The testimony in the case showed that there was no factual basis whatever to justify treating family physicians differently from all other physicians, either at the onset of the medical care program or presently. And, as is clear from a review of the screening procedure itself, BC/BSM in its private insurance does not distinguish between specialists and non-specialists, but rather pays a certain amount for the service regardless of who furnishes that service.

42 USC 1395u(b)(3) sets forth the obligation of the Secretary and carrier under Part B of the Medicare program. It provides, in pertinent part:

> "In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for *similar services* generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for *similar services*. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i), the prevailing charge recognized by the carrier and found ac-

ceptable by the Secretary for *similar services* in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for *similar services* in the same locality during the last preceding calendar year . . ." (Emphasis Added)

Further, 42 USC 1395(a) provides that nothing in the Medicare Act shall be construed to authorize the federal government or its agents to supervise or control the practice of medicine or the manner in which medical services are provided, or the selection, tenure, or compensation of officers or employees of health care providers, or the selection of medical care providers by beneficiaries.

The applicable regulation under 42 USC 1395 is 42 CFR 405.504(b). This regulation provides:

> "The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns."

Plaintiffs contend that defendants have never used the test of similar services as a basis for determining any physician's prevailing charge, and that the current reimbursement system of BC/BSM deviates from the statutory directives. They point out that for purposes

of determining any particular physician's "prevailing charge," defendant BC/BSM determines whether the physician is a "specialist" or "general practitioner" under its own definition. Once this decision or definition is rendered, that particular physician will receive reimbursement as the same rate as all other "specialists" or "general practitioners," no matter what type of procedure is being performed. Plaintiffs argue that no recognition of similarity of services exists in defendant's reimbursement decisions, even though a similarity of service is a standard by which such distinctions are to be made.

It is clear that the statute, 42 USC 1395u(b)(3) uses as the statutory scheme the customary charge of physicians for similar services in a specific locality. The statute further provides that nothing in the Medicare Act shall be construed as authorizing the federal government or its agent to supervise or control the practice of medicine or the manner in which medical services are provided, or the selection of Medicare providers by beneficiaries.

20 C.F.R. 405.504(b) authorizes a carrier to separate customary charges for similar services in computing the 75th percentile prevailing fee reasonable charge ceiling. In so doing, the regulation conflicts with the statute, which mandates that customary charges of physicians for similar services be the test for reimbursement.

The maintenance of three screens in the State of Michigan clearly violates 42 USC 1395(a) because it tends to influence the patient's choice of a physician, and reduces Medicare recipients' reimbursement solely by virtue of their choice of the type of physician to perform a particular medical service. The effect of the maintenance of these screens is to cause a Medicare recipient to go to a specialist for a particular service, or, if the recipient is not sophisticated enough to know the provisions, to cause him or her to suffer a lesser reim-

bursement than a person who had chosen a specialist to perform the type of medical service required. Even 20 C.F.R. 405.504(b) requires that any distinction between types of physicians for purposes of establishing prevailing fee schedules must be based upon a statistically valid analysis of the range of charges. The record in this case failed to show any statistically valid analysis of the billings of allopathic family physicians as compared with other types of family physicians.

There is no basis to justify the segregation of allopathic family physicians from all other types of physicians. Such segregation is not rationally related to any legitimate purpose of the Medicare statute. To lump MDs who are family physicians, but who have chosen not to become board certified family physicians for whatever motive, with chiropractors, dentists, and podiatrists for the purpose fo determining Medicare reimbursement defies all reason.

The effect of this can be dramatically shown in the case of Plaintiff Carole A. Diedrich, a Medicare recipient who has been disabled and has been a recipient since 1975. Her physician is Philip Lange, M.D., a family physician who has practiced in Lansing, Michigan, for approximately 23 years. Dr. Lange sees patients ranging in age from newborns through the very old, and treats a vast majority of medical conditions. He is on the staffs of St. Lawrence Hospital, Sparrow Hospital, and the Ingham County Medical Center. He is a graduate of the Wayne State University Medical School, and did a one-year internship and one-year residency in general medicine at St. Lawrence Hospital. He is an instructor at Michigan State University, and teaches students in family medicine. He is neither board eligible nor board certified by the American Board of Family Practice. For most procedures, Dr. Lange does not accept assignment from Medicare for

certain office calls, and charges patients $50 for a comprehensive examination, and $18 for routine office visit.

Where a physician does not accept an assignment, the patient is responsible for whatever charge the physician renders, the patient receiving reimbursement from Medicare in the amount of 80 percent of the reasonable fee, as determined by the carrier. The prevailing fee limitation for 1980 in the Lansing area is as follows: initial comprehensive visit, non-specialist $25, specialist $50; follow-up office visit non-specialist $10.70, specialist $12.30. Solely as a result of Mrs. Diedrich's choice of Philip Lange as her treating physician, she, while paying the same premium as other Medicare recipients, received less coverage for services performed than had she chosen a physician defined as a "specialist."

This example dramatically shows the effect of the screens established by BC/BSM in the reimbursement of Medicare recipients, and is the heart of plaintiffs' complaint in this action. Simply stated, Mrs. Diedrich, while paying the same premium as other Medicare recipients, receives less coverage for services performed for primary care because she goes to Dr. Lange than she would have received had she chosen a physician defined as a specialist.

The establishment of separate screens segregating non-board certified family physicians from all other physicians clearly is violative of the Medicare Act. To the extent that 20 C.F.R. 405.504(b) authorizes the screens set up by the defendants, that regulation is invalid.

Because the Court has found that the actions of defendants violate the Medicare statute, 42 USC 1395 et seq., it need not consider the constitutional arguments raised by plaintiffs.

A mandatory injunction will issue, directing defendants to provide that all physicians be included in a

single screen, separate from the screen for chiropractors, podiatrists, and dentists.

Plaintiffs may tax costs. A judgment may be entered in accordance with this opinion, which shall constitute the findings of fact and conclusions of law required by FRCP 52.

/s/ _____

HORACE W. GILMORE
United States District Judge

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS

[Filed Feb. 23, 1984]

JUDGMENT

BEFORE: JONES, Circuit Judge; PECK AND BROWN, Senior Circuit Judges.

ON APPEAL from the United States District Court for the Eastern District of Michigan.

THIS CAUSE came on to be heard on the record from the said District Court and was argued by counsel.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this court that this case is remanded to the Secretary for proceedings not inconsistent with this opinion.

Each party is to bear its own costs on the appeal.

ENTERED BY ORDER OF THE COURT

/S/ _____
JOHN P. HEHMAN,
Clerk

A TRUE COPY.
Attest:

/S/ _____
TOM ENNIGNUS
Deputy Clerk

APPENDIX F

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, ET AL., DEFENDANTS-APPELLANTS

[Filed May 30, 1985]

ORDER

BEFORE: JONES, Circuit Judge, PECK and BROWN, Senior Circuit Judges

The Court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this Court, and less than a majority of the judges having favored the suggestion, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/S/ John P. Hehman

JOHN P. HEHMAN, *Clerk*

APPENDIX G

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

1. 28 U.S.C. 1331 provides:

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

2. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), provides:

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

3. Section 1842 of the Social Security Act, 42 U.S.C. 1395u, provides in relevant part:

> (a) Authority of Secretary to enter into contracts with carriers
>
> In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of

the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services or a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

* * * * *

(b) Applicability of competitive bidding provisions; findings as to financial responsibility, etc., of carrier; contractual duties imposed by contract

* * * * *

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title;

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if pay-

ment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y(a) of this title, * * *

* * * * *

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

* * * * *

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge rec-

ognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of each year) in which the service is rendered.* * *

4. Section 1869(a) and (b) of the Social Security Act, 42 U.S.C. 1395ff(a) and (b), provides:

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, [footnote omitted] or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

5. 42 C.F.R. 405.504(b) provides:

> *Variation in range of prevailing charges.* The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns.